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Iowa Legislative Health Care Coverage Commission

Workgroup III

OVERVIEW OF PPACA HEALTH INSURANCE EXCHANGES AND STATE EXCHANGE OPTIONS

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CONTENTS

WORKS CITED

I. EXCHANGE OVERVIEW.

1. Introduction.

The Patient Protection and Affordable Care Act (PPACA) calls for states to create health insurance exchanges where individuals and small employers can shop for affordable health insurance policies. Exchanges are intended to create new health insurance marketplaces with greater retail competition than currently exists in state insurance markets. While exchanges may present significant new opportunities for increased coverage within Iowa, for both individuals and certain small businesses, they present a significant challenge to the state.

Possible Value And Risk of State-based Insurance Exchanges

- ✦ Maintain or expand regulatory authority over a large share of the insurance market.
- ✦ Prevent or reduce risk selection issues caused by varying rating and/or underwriting rules inside and outside the exchange.
- ✦ Better position states to coordinate benefits and eligibility across state public assistance programs.
- ✦ Provide a powerful tool at the state level to help advance other health care priorities.

Risks

- ✦ Difficulty inherent in creating new institutions.
- ✦ Requirement that exchanges must be self-sustaining by 2015.
- ✦ Dealing with tensions created by demands to keep operational fees and expenses to a minimum while providing high-quality customer service.

Changing a state's insurance market is a significant undertaking. The good news is that Iowa is ahead of many states when it comes to exchanges.[1] This is because Iowa enacted legislation to establish the *Iowa Insurance Information Exchange*, based on a Commission recommendation, during the 2010 legislative session. However, this Iowa exchange is quite different and far less complex than the exchanges contemplated in the PPACA.[2] Therefore much conceptual work and many policy decisions must take place before Iowa is prepared to declare to the federal government on January 1, 2013, that it is prepared to launch a new federal health insurance exchange on January 1, 2014. The critical issues that will have to be addressed include:

[1] Currently, only Massachusetts and Utah are operating exchanges.

[2] As you will recall during your workgroup deliberations the decision was made to propose a relatively simple ("lite") exchange geared towards providing information to consumers and small businesses about public and private coverage options.

Table 1. Exchange Responsibilities.	
States	Establish exchange(s), decide who operates the exchange(s) and the exchange governance structure; request federal funds for planning and startup costs; identify and secure long-term sources; decide on exchange scope and geographic area; address long term stability issues, including applying market reforms outside the exchange
Exchanges	Select, monitor, and oversee plan quality; assist prospective enrollees in choosing coverage options; administer premium tax credit/cost sharing programs; coordinate with state Medicaid/CHIP and S-CHIP agencies; administer individual and employer responsibility requirements.
Federal Government	Establish minimum requirements for plans offered in exchanges; provide exchange planning and operational startup funds; establish and operate exchanges in states that choose not to participate in exchanges or fail in their attempt to establish exchange(s); establish consumer assistance standards; develop eligibility and enrollment procedures and systems; monitor and oversee exchange compliance and financial solvency.

- What are Iowa's goals in creating an exchange:
  - ✓ To increase health insurer accountability?
  - ✓ To increase system affordability and cost containment?
  - ✓ To transform the way insurers do business and contract with medical providers?
  - ✓ To create an easy-to-use information and shopping tool for consumers?
  - ✓ To moderate premium increases?
- How will Iowa integrate the Iowa Insurance Information Exchange into a new federal exchange?
- How should the exchange be structured to achieve those goals?
- To what extent will creating an exchange require the state to change its current health insurance market?
- What policy changes and choices should the state consider to promote affordability and reduce adverse risk selection on the exchange?
- How can Iowa configure an exchange to promote seamless coverage transitions between public and private insurance coverage?

Table 2. Critical PPACA Exchange Development Deadlines.	
Sep. 23. 2010	HHS will establish enrollment standards and protocols for state and (default) federal exchanges. [§1561]
Mar. 22, 2011	Original date HHS was going to begin issuing grants. Instead issued *exchange planning grant* in July 2010. [§1311(a)]
Mar. 23, 2011	HHS will develop standards for compiling and providing enrollees with benefit and coverage summaries and benefits. [§1001]

Table 2. Critical PPACA Exchange Development Deadlines.	
Jan 1, 2013	HHS approves state declaration that it will be both willing and able to launch a fully operational exchange on Jan. 1, 2014. [§1321(c)]
July 1, 2013	Co-Ops can begin receiving federal loans. [§1322(b)]
Jan 1, 2014	Exchange is fully operational. [§1311(b)]

For Iowa to realize the promise of reduced uninsurance and greater coverage affordability and choice, the state will have to create a well-designed exchange whose governing rules and structure are suited to enhancing carrier competition and choice of coverage. The exchange will also have to be flexible enough to adapt to the evolving health insurance marketplace that will exist in 2014 and beyond.

This paper will help to familiarize you with issues and decisions that the state will need to resolve before launching a fully operational exchange in 2014, and will include:

- A brief summary of exchanges,
- The key decision points that states must consider in establishing an exchange, and
- A discussion of the risks and opportunities available to those states that choose to establish exchanges.

2. Exchange Summary.

The P*atient Protection and Affordable Care Act* imposes the first-ever national health care coverage mandate. In a country still dominated by employer-sponsored coverage, insurance exchanges are considered the key policy strategy to provide individuals and families without employer sponsored coverage with a reasonable means to comply with the mandate when it goes into effect in 2014. Exchanges are also seen as the solution to the long vexing problem of affordable coverage for small businesses (See *Chart 1. Health Insurance Coverage By Type, 1999-2009 and Table 3. Iowa Medicaid and Medicare Enrollment, 1999-2009*). The goal of exchanges is, therefore, to make the purchase of health insurance coverage easier and less expensive for both individuals and small businesses. The promise is that beginning January 1, 2014, there will be:

- **New marketplaces for individuals and small employers.** Individuals with incomes above 133 percent of the federal poverty level (FPL) and who do not have access to employer-sponsored coverage and small employers will be able to buy insurance on an exchange.[3]

- **New subsidies.** Individuals without employer-sponsored coverage and not eligible for public coverage and with incomes between 133 percent and 400 percent of the FPL will be eligible to receive a sliding scale federal subsidy to buy their own coverage on an exchange. Exchange-eligible small employers will also be eligible for federal subsidies to help them buy employee coverage.

[3] The FPL for 2010 is $22,050 for a family of four and $10,830 for individuals.

Exchanges are also intended to provide coverage choices. Individual consumers will be able to enroll in any plan for which they are eligible (and can afford). For employees purchasing on an exchange, it is important to note that employers will be able to specify the level of coverage they will financially support and employees may choose any plan that offers that level of coverage.

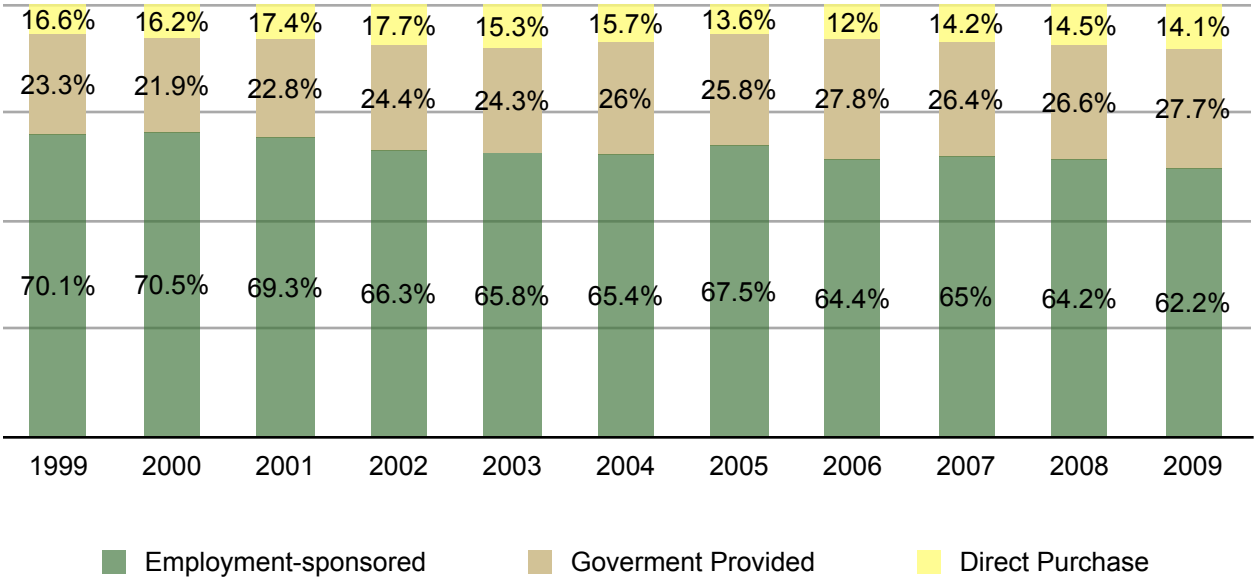
Nothing in the PPACA limits an insurer from offering coverage outside of an exchange, nor does the law require any individual or employer to purchase coverage from an exchange.[4]

A. Exchange Types.

The PPACA authorizes states to create entities known as "American Health Benefit Exchanges" which must be fully operational beginning on January 1, 2014. For those states who decline to create an exchange, the federal government will step in and establish an exchange in the state. This "federal" exchange can either be operated directly by the federal government or by a nonprofit entity approved by the federal government.

For small businesses the Act provides the *Small Business Health Options Program* (SHOP Program) where businesses with up to 100 employees can purchase coverage.[5] States may choose to operate both an exchange and a SHOP Program or they may choose to operate a single combined exchange for both individual and small business purchasers. [PPACA §1311]

Chart 1. Health Insurance Coverage By Type, 1999-2009*



Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplements.
www.census.gov/apsd/techdoc/cps/cpsmar10.pdf

[4] Members of Congress, however will no longer be eligible to buy coverage from the Federal Employee Health Plan, and will be required to buy coverage through an exchange if they want to be covered by the federal government as part of their public service commitment. PPACA §1312

[5] Until Jan. 1, 2016, states can limit exchanges to businesses with 50 or fewer employees. Starting in 2017, states have the option to allow businesses with greater than 100 employees to buy coverage on an exchange. PPACA §1312

1. **Multi-state Plans.** The PPACA requires the US Office of Personnel Management to contract with insurers so that a minimum of two multi-state plans will be available in each exchange, with at least one multi-state plan offered by a nonprofit entity. The multi-state plans will be required to be licensed in each state and adhere to the same rules as "qualified health plans."[6]

Table 3. Iowa Medicaid and Medicare Enrollment, 1999-2009

	Medicaid		Medicare	
	%	#	%	#
1999	7.1	204,000	14.9	427,000
2000	6.5	187,000	15.7	451,000
2001	7.8	224,000	15.0	429,000
2002	9.5	275,000	15.0	436,000
2003	8.0	233,000	15.9	465,000
2004	12.0	347,000	14.6	425,000
2005	11.2	327,000	14.4	419,000
2006	14.2	413,000	14.8	432,000
2007	11.5	342,000	15.0	445,000
2008	11.9	357,000	14.5	432,000
2009	14.2	426,000	13.5	404,000

Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplements. www.census.gov/apsd/techdoc/cps/cpsmar10.pdf

2. **CO-OPS.** The federal government will also provide $6 billion for interested parties to create nonprofit, member-run health insurance companies ("Consumer Operated and Oriented Plans") in each state.

B. Minimum Exchange Functions (Performance Requirements).

[6] A "qualified health plan" is a plan that:
- Is certified by each exchange through which it is offered
- Provides the essential benefits package
- Is offered by an issuer that:
  - ✓Is licensed and in good standing in each state in which it is offered
  - ✓Agrees to offer at least one silver plan and one gold plan
  - ✓Agrees to charge the same premium whether the plan is sold through the exchange or outside the exchange
  - ✓Complies with other requirements of the Secretary and the exchange

Qualified health plans may offer coverage through a primary care medical home and vary premiums by rating area. [PPACA §1301]

The PPACA imposes the following minimum requirements on exchanges [PPACA §1311]:

- Certify that health plans are qualified to be offered in the exchange. Before a plan can be certified as an exchange-based "qualified health plan" a plan must meet certain requirements designed to assure that it will:[7]
  - ✓ Not discourage enrollment of persons with significant ongoing health issues;
  - ✓ Meet network adequacy requirements and allow for a sufficient choice of providers, including those essential community providers who serve low income persons;[8]
  - ✓ Be accredited for quality measures by an entity recognized by the HHS secretary; and
  - ✓ Use standard means for presenting health benefit options;
- Rate "qualified health plans" per federal standards.
- Maintain a website where enrollees can obtain standardized comparative information about all exchange-based health plans (bronze, silver, gold, platinum and catastrophic plans for young adults).
- Require exchanges and participating plans to use "plain" language when disclosing:
  - ✓ Claims payment policies and practices; periodic financial disclosures;
  - ✓ Data on enrollment, claim denials, and rating practices;
  - ✓ Cost-sharing information and costs for out-of-network coverage; and
  - ✓ Enrollee and participant rights;
- Require qualified health plans to provide timely information about cost-sharing requirements for specific items or services.
- Require qualified health plans provide information to the exchange and enrollees on health plan quality measures and performance.
- Operate a toll-free telephone assistance hotline.
- Require plans to use a uniform enrollment form and a standardized format for discussing health benefit options.
- Provide information to the public about Medicaid, CHIP or other state or local public program eligibility requirements, and to coordinate enrollment procedures with the proper agencies.
- Communicate with employers regarding changes in employee coverage.
- Provide an electronic calculator so the public and enrollees (prospective enrollees) can determine the actual cost of coverage after any premium tax credit and any cost-sharing reduction has been applied.
- Require plans to only contract with providers who have implemented HHS required quality improvement mechanisms.

[7] Exchanges will also be required to decertify plans that fail to meet the minimum requirements and to recertify plans that regain eligibility to participate on the exchange.

[8] See Public Health Services Act (PHSA) §2702 (c).

- Require plans to submit justifications for any premium increases before their implementation and post the information on the exchange website. The justifications must be taken into account in the plan certifying process.
- Allow plans to contract with hospitals with more than 50 beds only if the hospitals use a patient safety evaluation system and provide discharge education and counseling, comprehensive discharge planning, and post discharge reinforcement by a health care professional.
- Require plans to submit to the exchange, the secretary of HHS, and the insurance Commissioner as well as publicly disclose the following information:
  - ✓ Claims payment policies and practices;
  - ✓ Periodic financial disclosures;
  - ✓ Enrollment and disenrollment data;
  - ✓ Data on the number of claims that are denied;
  - ✓ Data on rating practices;
  - ✓ Information on cost-sharing and payments for out-of-network coverage; and
  - ✓ Information on enrollee rights.
- Grant certifications for individuals exempt from the individual responsibility penalty when no affordable qualified health plan is available through the exchange or the individual's employer. Plans will be required to communicate closely with the Treasury Department in certifying individual eligibility and coverage exemptions.
- Establish a "Navigator" program to award grants to entities for promoting public education about exchanges and how to participate in the them.[9]
- Be accountable to the federal government by providing annual reports to HHS on exchange activities and finances (receipts and expenditures).
- Perform in a transparent fashion by publishing online, the average costs of licensing, regulatory fees, administration, and funds lost to waste, fraud, and abuse.

As they perform the above activities, exchanges will also be required to seek out the opinions of enrollees, small business purchasers, "Navigators" (enrollment facilitators), the self-employed, State Medicaid officials and representatives and advocates for hard to enroll groups.

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[9] Navigator programs will focus on providing culturally and linguistically appropriate public education; facilitating enrollment in qualified health plans; and referring consumers with complaints/questions to appropriate agencies. Entities eligible to serve as navigators include:

- Trade industry and professional associations
- Commercial fishing industry organizations
- Chambers of commerce
- Unions
- Resource partners of the US small business administration
- Licensed insurance producers, and
- Other entities that are not insurers and do not receive any direct or indirect compensation from insurers in connection with planned enrollments or disenrollments.

HHS, in conjunction with the states, will develop standards to insure that information provided by navigators is "fair, accurate, and impartial. PPACA §1311

Of course, before any plan can be certified as an exchange participant it will also be required to follow PPACA insurance market regulations regarding guaranteed issue, premium rating, and prohibitions on preexisting condition exclusions.

C. Eligibility to Participate in an Exchange.

Eligible individuals include American citizens and non-incarcerated **legal** immigrants without access to affordable employer provided coverage. Small businesses will be eligible to participate in a SHOP Program if the state decided to participate in the SHOP Program. (See p. 3)

The federal government estimates that by 2019, about 24 million persons will buy their own coverage from an exchange, and approximately 5 million persons will work for employers who allow their employees to choose exchange-based coverage.[10]

D. Exchange Plans.

1. Four Categories of Exchange Plans.

Exchange plans will be offered in four categories:

- **Bronze:** Plans must provide coverage with benefits that are actuarially equivalent to **60 percent** of the full actuarial value of benefits under the plan.
- **Silver:** Plans must provide coverage with benefits that are actuarially equivalent to **70 percent** of the full actuarial value of benefits under the plan.
- **Gold:** Plans must provide coverage with benefits that are actuarially equivalent to **80 percent** of the full actuarial value of benefits under the plan.
- **Platinum:** Plans must provide coverage with benefits that are actuarially equivalent to **90 percent** of the full actuarial value of benefits under the plan.

In addition, exchanges will be required to offer a catastrophic type benefit plan for young adults (under age 30) and persons exempt from the PPACA individual mandate because no affordable plan is available to them. This catastrophic type plan must provide the "essential benefits package," have a limited deductible, and provide at least three primary care visits.

Exchanges may not exclude plans:

- Because they are fee-for-service plans;
- By imposing premium price controls;
- On the basis that a plan provides necessary medical treatments in circumstances that the exchange deems unnecessary or too costly.

2. State "Basic Health Plan". The PPACA allows states to choose to implement a Basic Health Plan (BHP) to provide coverage to children, parents, or adults not eligible for Medicaid and who have incomes between 133 to 200 percent of the FPL. States would enter into contracts with health plans to provide the coverage. At a minimum, BHP coverage must be at least equivalent to plans offered

[10] Kaiser Family Foundation, "Explaining Health Care Reform: Questions About Health Insurance Subsidies," April 2010, http://www.kff.org/healthreform/upload/7908-02.pdf.

on the exchange with respect to benefits, premiums, and cost-sharing levels. To fund these plans, states would receive 95 percent of the federal funds that would have been provided to them toward exchange subsidies.[11] States that choose to establish BHPs will face critical coordination issues between the state's existing programs (Medicaid and S-CHIP) and the BHP.

E. Exchange Financial Support for Individuals and Families.

In 2014, the federal government will begin providing refundable (and advanceable[12]) premium credits and cost-sharing subsidies through an exchange to American citizens and legal residents with incomes between 133 percent and 400 percent of the FPL.[13] Further, legal immigrants who are not eligible to enroll in Medicaid for the first five years of US residence will also be eligible for premium credits.

Generally, individuals who are eligible for publicly supported coverage and persons who are offered coverage through employment will not be eligible for premium credits unless their employer's plan has an actuarial value of at least 60 percent or if the employee's share of premium cost is greater than 9.5 percent of the employee's income.

Employers who provide employees with "minimum essential coverage" will be required to provide employees with incomes below 400 percent of the FPL and who contribute more than 8 percent but less than 9.8 percent of their income towards the cost of coverage with "free choice vouchers." The vouchers can then be used towards covering the cost of an exchange-based plan.

1. Premium Tax Credits. The sliding scale premium credits will be based off of the cost of the second lowest cost "silver plan" available in the area. The law takes into account that premiums have generally grown more rapidly than incomes, therefore the PPACA provides for adjustments to the percent of premium that persons will have to pay to reflect this economic reality. For subsidy-eligible enrollees, premium contributions will be limited as indicated in Table 4. Limits on Premium Contributions. Starting in 2019, if subsidies (aggregate premiums and cost-sharing) exceed 0.54 of US gross domestic product, premium percentages will be adjusted for the excess of premium growth over the consumer price index (CPI).

Table 4. Limits on Premium Contributions.

Income Level	Premium as a Percentage of Income
Up to 133% FPL	2% of income

[11] PPACA §1331.

[12] "Advanceable" tax credits are available even when individuals have no tax liability. This type of credit allows the subsidized individual to receive funds when they are needed, that is when a premium has to be paid. This avoids a potential cash flow issue, where if the credits were not advanceable low and moderate income persons would have to wait until filing their income tax returns to request and subsequently, receive the credit.

[13] Under the PPACA, almost all persons with incomes below 133% of the FPL will be eligible to enroll in Medicaid. Estimates in Iowa are that between 75,000 and 100,000 additional persons will be eligible to enroll in Medicaid in 2014.

Table 4. Limits on Premium Contributions.	
Income Level	**Premium as a Percentage of Income**
133 - 150% FPL	3-4% of income
150 - 200% FPL	4 - 6.3% of income
200 - 250% FPL	6.3 - 8.05% of income
250 - 300% FPL	8.05 - 9.5% of income
300 - 400% FPL	9.5% of income

Table 5 provides a hypothetical example of how the premium subsidy tax credit will work.

Table 5. Hypothetical Subsidy Example.
• Jane is 45 years old and has a 2014 income of 250% FPL (approx. $28,735)* • The cost of the second lowest Silver plan in Jane's area is $5,733 (See p.8) • Per the PPACa, Jane will not have to pay more than 8.05% of her income ($2,313) to participate in this Silver plan. • Jane's tax credit would amount to $3,420 ($5,733 - $2,313)
Source: Kaiser Family Foundation, "Explaining Health Care Reform: Questions About Health Insurance Subsidies," April 2010, http://www.kff.org/healthreform/upload/7908-0. Poverty projection is based on projected change in consumer price index, available at www.cbo.gov/budget/econproj.shtml.

If subsidy-eligible persons want to buy a more expensive plan they will have to pay the difference between the cost of the second lowest cost "silver plan" and the plan they wish to purchase.

2. Cost-Sharing. Premium subsidies are designed to help low and moderate income persons when they purchase **coverage**. Cost-sharing assistance is designed to help low income individuals at the point where they use **health care services**. Cost-sharing assistance will be available for those with incomes up to 250 percent of the FPL and will allow individuals and families to access plans with lower deductibles and co-payments (that is plans that have a higher actuarial value).In essence, the PPACA allows persons with lower incomes to benefit from reduced cost-sharing so that their plan on average pays for a greater share of covered benefits. This benefit varies by income as shown in Table 6.

Table 6. Plan Actuarial Values - For Lower Income Persons.	
Income Level	**Actuarial Value**
100 - 150% FPL	94%
150 - 200% FPL	87%
200 - 250% FPL	73%

While the PPACA does provide limits on out-of-pocket spending (see below), the law does not indicate any particular combination of deductibles, co-payments and coinsurance that coverage plans have to use to meet the actuarial value rules. This means that plans can vary, in that one plan may offer higher deductibles, but lower co-payments applicable at time of service. Conversely, a plan could choose lower deductibles, but impose higher co-payments (or coinsurance) payable at the time of service. Commentators indicate this aspect of the law may be addressed in future rule-making.

3. Limits on Out-of-pocket Expenses. Another PPACA financial protection is the limit on out-of-pocket expenses for "essential health benefits.[14] These limits are based on the maximum out-of-pocket limits for health savings account qualified health plans.[15,16] Until 2014, these amounts will be indexed to changes in the CPI.[17] Beginning in 2014, these limits will be indexed to changes in the cost of coverage.

Persons with incomes at or below 400 percent of the FPL are eligible for lower out-of-pocket payment limits as shown in Table 7.

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[14] An essential health benefits package is required to cover the following general categories of services:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care.
- The HHS Secretary will determine the scope of benefits,which must be equal to the scope of benefits under a typical employer-based plan. A qualified health plan may choose to provide benefits in excess of the essential benefits package.

[15] 2010: Single coverage $5,950; family coverage $11,900.

[16] Deductibles for plans in the small group market are limited to $2000 (individual) and $4000 (family). The amounts are indexed to average premium growth and may be increased by the maximum amount of reimbursement available to an employee under a flexible spending arrangement. PPACA §1302.

[17] See 26 U.S.C. §22 3(g).

Table 7. Limits on Out-of-pocket Expenses.	
Income Level	**Reduction in Out-of-pocket Payment Liability**
100 - 200% FPL	2/3 of the maximum
200 - 300% FPL	1/2 of the maximum
300 - 400% FPL	1/3 of the maximum

Table 8 provides a hypothetical example of how the out-of-pocket limit will work for lower income persons.

Table 8. Out-of-pocket Limit Example.
• John is 35 years old and has an income at 150% FPL • If he buys his plan on an exchange, the out-of-pocket spending limit will be 2/3 of the generally applicable maximum value. • In 2010, John would have maximum out-of-pocket spending of $1,981 (single coverage) or $3,963 (family coverage).
Source: Kaiser Family Foundation, "Explaining Health Care Reform: Questions About Health Insurance Subsidies," April 2010, http://www.kff.org/healthreform/upload/7908-0.

F. Exchange Governance.

The PPACA requires that an exchange be operated by a government agency or by a nonprofit entity established by the state. States can establish one single exchange for both individuals and small businesses or they can establish a separate SHOP Program for small businesses. States are also given the option of joining with other states to form regional exchanges, and can choose to operate more than one exchange as long as each exchange operates in a separate geographic area.

G. Exchange Funding.

The federal government is using several mechanisms to assist states with the start-up costs of developing an exchange. There are grants for exchange planning and exchange implementation. Iowa, with the Department of Public Health as the lead agency, applied for an exchange planning grant in August 2010. It is anticipated the state will receive a little over $1 million to assist in planning (See Appendix A for a copy of Iowa's grant application). The implementation grants are scheduled to be released in the spring of 2011.

Besides grant funding, the federal government will provide funds to operate an exchange until January 1, 2015, at which time states must be able to demonstrate that their exchanges can operate as self-sustaining entities. [PPACA §1311] States will be required to allow an exchange to charge participation fees to insurers who sell plans on the exchange or to provide an exchange with other means of generating operational funds.

II. STATE OPTIONS.

This section will focus on the issues that exchanges must successfully resolve if they are going to fulfill their promise of expanding affordable coverage, increasing health care quality and possibly reducing the cost of care.[18]

While exchanges will not be operational until 2014, if Iowa wishes to establish an American Health Benefit Exchange, it will face considerable difficulty in doing so unless it begins the planning process at the earliest possible date. Acting slowly could compromise the state's ability to make optimal strategic choices. Conversely, acting too quickly, without a complete understanding of the choices available in the Act, could result in costly disruptions to the state's insurance market.[19]

1. State Flexibility.

The PPACA does provide states with significant flexibility in designing exchanges. Iowa, like all states, will have the option:

- To establish or decline to establish an exchange in the state;
- To design separate exchanges for individuals and small businesses (SHOP Program) or set up one exchange for both markets;
- To create or join a regional exchange with other state partners;
- To operate several exchanges within Iowa's own boundaries, serving geographically-defined areas;
- To determine, if between 2014 and 2016, it should define small employers as those firms with up to 50 employees, versus the PPACA standard of 10 employees;
- To decide if it should implement a state Basic Health Plan to provide coverage to children, parents, or adults not eligible for Medicaid and who have incomes between 133 to 200 percent of the FPL; and
- To decide if it should contract with the state Medicaid program (Iowa Medicaid Enterprise) for exchange eligibility determinations.

These design choices, coupled with Iowa's ability to obtain long term financing to support exchange operations beyond 2016, will have the greatest affect on the exchange's ability to create a new insurance marketplace where individuals, families and small businesses can shop for affordable coverage.

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[18] This section of the paper relies heavily on the work of Dr. Timothy S. Jost, especially his paper for the *Commonwealth Fund:* Jost, Timothy S., "Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues," July 2010 *Washington and Lee University School of Law*, http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2010/Jul/Health-Insurance-Exchanges-and-the-Affordable-Care-Act.aspx.

[19] It's important to remember there is an existing body of knowledge regarding health insurance exchanges. Insurance exchanges developed out of the managed competition concepts developed by economist Alain Enthoven in the late 1980s. OVer the past three decades, states and private interests have developed exchanges, but they were more often referred to as "purchasing cooperatives," "health alliances," and most recently "connectors" (Massachusetts). Health Alliances were an important part of the Clinton health care reform efforts. Successful programs that had exchange-like features include: *Federal Employees Health Benefits Program*, *California Public Employees Retirement System*, *Dane County (Wisconsin) Public Employees Program*, *Massachusetts Connector*, and the *Connecticut Business & Industry Association's Health Connections*. Unfortunately, there have been significant exchange failures—including exchanges in California, Texas, Florida, Colorado, and North Carolina—despite enjoying some initial success. See Jost, p. 2.

What Is "Adverse Selection"?

- Adverse selection is the tendency of people with significant potential to file claims, wanting to obtain insurance coverage.
- In the context of health insurance coverage, this means that persons in very poor health will have a greater desire to buy coverage than persons in better health.
- A traditional response to the risk of *adverse selection* is the attempt to reduce exposure to large claims by making an insurance product less appealing either by raising premiums or screening out high risk insurance applicants.

Adverse Selection in the Exchange Context

"Adverse selection — the separation of healthier and less-healthy people into different insurance arrangements — will occur if a disproportionate number of people who are in poorer health and have high health expenses enroll in coverage through the insurance exchanges, while healthier, lower-cost people disproportionately enroll in plans offered through the individual and small-business markets *outside* the exchanges." [Lueck, S., *States Should Structure Insurance Exchanges to Minimize Adverse Selection*, Center on Budget and Policy Priorities, August 17, 2010 http://www.cbpp.org/cms/index.cfm?fa=view&id=3267]

2. **Adverse Selection – An Essential Implementation Issue.**
   According to Jost:

> The single most important reason why some exchanges have not succeeded in the past is that **they became the victims of adverse selection—they were unable to capture a large enough share of the healthy participants in the insurance market.** In effect, these exchanges attempted to offer better coverage, or more affordable coverage, to too many individuals or groups with unfavorable risk profiles and were unable to attract enough healthy enrollees. [Emphasis added][20]

The risk is that whenever individual (or small-group) coverage is easily available outside an exchange, healthy persons (or a group) will find, and often purchase, less expensive policies outside the exchange, or in the case of some businesses, pursue the option to self-insure. The result could well be an exchange that becomes as de facto high-risk pool, with unattractive (from a health risk perspective) enrollees and with increasingly unaffordable coverage.

[20] Jost, p. 3, citing L. Blumberg and K. Pollitz, *Health Insurance Exchanges: Organizing Health Insurance Marketplaces to Promote Health Reform Goals* (Washington, D.C.: Urban Institute, 2009); Wicks, Elliott K. "Health Insurance Purchasing Cooperatives", Nov. 11, 2002, Commonwealth Fund, http://www.commonwealthfund.org/Content/Publications/Issue-Briefs/2002/Nov/Health-Insurance-Purchasing-Cooperatives.aspx; Rand Compare, "Effects of Purchasing Pool Options," (2009), http://www.randcompare.org/policy-options/purchasing-pools; & C. McGarr, "A Texas-Sized Health Care Failure," *New York Times*, Oct. 6, 2009.

Exchange Failure– A California Example

PacAdvantage was a California small-business insurance pool that operated from 1993 to 2006, until it was brought down by growing adverse selection. At its most successful, PacAdvantage covered 150,000 lives. Unfortunately, PacAdvantage was attractive to people with significant medical costs. This was in part because its rules regarding pricing plans were more favorable than the rules in the regular small-group market for firms with sicker workers. PacAdvantage started out by not allowing insurers offering PacAdvantage coverage to charge higher premiums to small firms with sicker workers, which insurers in the outside small-group market did to some extent. The result was a concentration of sicker individuals in PacAdvantage plans. While at the same time small businesses with less risky workers continued to obtain coverage in the regular small-group market.

According to Peter Lee, a former official at the Pacific Business Group on Health (which operated PacAdvantage), this rule framework "drove up premiums inside the exchange, causing healthier people to drop out. This is known in the insurance business as a classic 'death spiral.'" (Lueck, S. citing Peter Lee, "What People Don't Know about Health Insurance Exchanges," *Health Affairs* blog, August 12, 2009. See also, Elliot K. Wicks, "Building a National Health Insurance Exchange: Lessons from California," California HealthCare Foundation, July 2009.)

Predictably, riskier and less-healthy individuals and small groups continued to enroll in PacAdvantage, and premiums rose ever higher compared to the regular market. PacAdvantage became even less attractive to healthy individuals and groups and eventually, as PacAdvantage was simply no longer a viable entity, the pool was shut down.

While, as the PacAdvantage example demonstrates, exchanges can fail if ever-higher premiums and coverage of ever riskier (sicker) exchange participants leads healthy individuals to abandon an exchange to find less costly coverage outside the exchange, there are a number of ways to mitigate the risk. First, it is important to realize that past successful exchange-like entities share some common characteristics:

- A large and diverse population (e.g. the *Federal Employees Health Benefits Program* FEHBP);
- A bar on outside competition; and/or
- Significant advantages made available only to exchange participants.[21]

A. PPACA Protections Against Adverse Selection.

The PPACA provides a number of important mechanisms to reduce the risk of adverse selection against an exchange, however while powerful, these mechanisms still leave room for concern. For example, the Act allows both individual and group health insurance markets to exist outside the exchange, providing opportunities for healthier individuals to shop for and obtain less expensive coverage outside the exchange.[22] In addition, the Act also allows "grandfathered plans" to operate

[21] e.g. in Massachusetts, premium subsidies are available only through the state's Health Connector. Lischko, A., Bachman, S. and A. Vangeli, The Massachusetts Commonwealth Health Insurance Connector: Structure and Functions," May 2009, Commonwealth Fund, http://www.commonwealthfund.org/Content/Publications/Issue-Briefs/2009/May/The-Massachusetts-Commonwealth-Health-Insurance-Connector.aspx.

[22] PPACA §1312(d) PPACA § 1312(d)(1), (3) and (4).

outside the exchange.[23] The following sections will describe the PPACA provisions that should act to reduce the risk of adverse selection against an exchange.

1. **PPACA Financial Support Mechanisms.** The most important provision protecting exchanges against the risk of adverse selection are the Act's financial support mechanisms for low and moderate income persons. These premium assistance credits and cost-sharing reduction payments are only available to persons enrolled in exchange-based coverage.[24] Since these subsidies become quite substantial at lower income levels, it appears likely the vast majority of individuals and families eligible for these subsidies will purchase coverage through an exchange.

In addition, small employers will have access to tax credits through the exchange, but only for the first two years the employer offers insurance through the exchange.[25] This provision should motivate employers to purchase employee coverage through the exchange, especially at the critical initial start-up phase. Finally, for those states that mandate the coverage of certain benefits that are not part of the PPACA "essential benefits package," the Act requires states to cover the costs of those benefits only when they are provided by "qualified health plans" on an exchange.[26]

Beyond these financial incentives, there are additional ways in which the Act will tend to discourage adverse selection against the exchange. These include:

- **Encouraging coverage.** The PPACA amends the Internal Revenue Code to require individuals to carry "minimum essential coverage."[27] Persons without employer-sponsored coverage or public coverage will have to choose between obtaining their own coverage or paying a penalty. This disincentive is designed to help persuade healthy people from forgoing coverage and using the exchange instead.
- **Important PPACA insurance reforms operate both inside and outside exchanges, potentially reducing the risk of adverse selection.** These provisions include:
  - ✓ A bar on lifetime or annual dollar coverage limits.[28]
  - ✓ Requiring insurance plans to allow enrollees to participate in **approved** clinical trials (related to the prevention, detection, or treatment of cancer or other life-threatening diseases) and to provide coverage for the routine patient costs of participating in the the trials;[29]
  - ✓ Allowing premium variation based only on **age** (3:1), **geographic region**, purchase of **individual** or **family** coverage, or use of **tobacco** (1.5:1); and barring rating based on health status;[30]

[23] PPACA § 1251(a). See Appendix 2 – "Grandfathered Plans."

[24] See Internal Revenue Code §36B(b)(2) (Added by PPACA §§ 1401 and 1402(b)(1).

[25] PPACA §1421.

[26] PPACA §1311(d)(3)(B)(ii).

[27] Internal Revenue Code §5000A(a) & (f), added by PPACA §1501(b).

[28] PHSA §2711 (Added by PPACA §1001. Until 2014, "restricted annual limits" will be allowed. Also, limits will continue to be allowed for specific covered benefits that are not part of the "essential benefits" package.

[29] PHSA §2709 (Added by PPAACA §10103).

[30] PHSA §2701 (Added by PPACA §1201).

- ✓ Guaranteeing issue and renewability of coverage;[31]
- ✓ Barring preexisting-condition exclusions; and[32]
- ✓ Barring waiting periods of longer than 90 days.[33]

- **Essential benefits.** Requiring individual and small group plans, inside and outside an exchange to cover an "essential health benefits" package which will have to provide coverage equal to the coverage provided by a typical employer plan. [34]
- **Limits on out-of-pocket expenses.** Starting in 2014, out-of-pocket expenses for individuals enrolled in plans inside and outside exchanges will not be allowed to exceed the levels allowed for high-deductible health plans linked to health savings accounts. Additionally, deductibles in the small-group market cannot exceed $2,000 for individuals and $4,000 for families.[35]

These requirements mean that plans operating outside the exchange will have relatively few opportunities to attract healthier persons to their plan by setting higher cost-sharing limits or by simply excluding the types of benefits that might hold more interest to sicker persons. Additionally, commentators have suggested that because exchanges will provide "direct marketing" of insurance products to the public it will reduce a practice referred to as "street underwriting" whereby agents, brokers or carriers engage in marketing practices designed to move high cost persons onto an exchange and low cost persons away from an exchange.[36]

Other PPACA provisions that have the potential to reduce the risk of adverse selection include:

- **Single pool treatment.** Except for enrollees in grandfathered plans, insurers will be required to treat all individuals enrolled in their plans as members of a single pool, and all small-group market enrollees as another single pool when setting premiums (with the caveat that a state can choose to require insurers to treat members of both pools as one single pool).[37]
- **Same premium requirement.** All qualified health plans must charge the same premium rate for a qualified health plan irrespective of whether the plan is sold inside or outside an exchange.[38]

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[31] PHSA §§ 2702, 2703 and 2705 (Added by PPACA §1201).

[32] PHSA §§ 2704 and 2705, amended by PPACA §1201.

[33] PHSA §2708 (Added by PPACA §1201).

[34] PPACA §1302(b)(1), PHSA §2707 (Added by PPACA §1201), and PPACA §1302(b)(2).

[35] PPACA 1302(c) and PHSA §2707 (Added by PPACA §1201). Deductibles for plans in the small group market are indexed to average premium growth and may be increased by the maximum amount of reimbursement available to an employee under a flexible spending arrangement.

[36] Jost, p. 4.

[37] PPACA §1312(c).

[38] PPACA §1301(a)(1)(C)(iii).

- **Risk adjustment measures.** The PPACA provides three risk-adjustment programs—two transitional measures and one permanent one to reduce the risk of adverse selection against an exchange:[39]
  - ✓ A transitional reinsurance program lasting 36 months (from 2014 to 2016), administered by the states through contracts with private reinsurers.[40]
  - ✓ A risk-corridor program (operating between 2014 and 2016) for individual and small-group market qualified health plans.[41]
  - ✓ A **permanent** risk-adjustment program administered by the states which will cover plans inside and outside the exchange, but which will not affect self-insured or grandfathered plans. The program will require that an assessment be levied on plans with low-risk enrollees with the funds then directed to support plans with high-risk enrollees.[42]

It is important to note that the PPACA pooling rules have important restrictions that may hamper their effectiveness in reducing the risk of adverse selection. For example, the rule requiring that carriers offering identical plans inside and outside the exchange to must charge the same premium in both markets is undercut by the reality that the PPACA will not compel carriers participating in both markets to offer the same plans inside and outside the exchange.

Yet, while these measures can attenuate the risk of adverse selection, they are not foolproof. As Sarah Lueck notes in "States Should Structure Insurance Exchanges to Minimize Adverse Selection":

> But while risk adjustment will reduce adverse selection, it is unlikely by itself to fully protect against it. The Congressional Budget Office (CBO) has noted that existing risk-adjustment systems "tend to overpredict the costs of beneficiaries who end up with low health care spending and to underpredict the costs of those who end up with high health spending." In other words, risk adjustment is very difficult to do with sufficient accuracy to ensure that insurers are actually compensated based on the populations they enroll. Even when done well, it generally compensates for only *some* of the differences in health costs between healthier and less-healthy groups of beneficiaries. As CBO has warned, the inability of current risk-adjustment systems to fully adjust for differences in health care costs between low-and high-cost groups means that, among plans in the same risk-adjustment system, "premiums for enrollees in plans that attract higher-cost beneficiaries [could] rise substantially over time." Moreover, implementing effective risk adjustment under the Affordable Care Act will initially be hampered by the lack of comparable

[39]Hall, Mark, A. "The Three Types of Reinsurance Created by Federal Health Reform," *Health Affairs,* 2010 29(6):1168–72, http://content.healthaffairs.org/cgi/content/abstract/29/6/1168

[40] PPACA §1341.

[41] PPACA §1342.

[42] PPACA §1343.

data on the health status of enrollees in the myriad of plans inside and outside the exchanges.[43]

B. What Can States do to Minimize Risk?

The PPACA contains four voluntary provisions that states can use to reduce the risk of exchange failure:

- Require the rules for markets outside an exchange be consistent with the rules that apply to the exchange;
- Require insurers to offer the same coverage products inside and outside an exchange;
- Merge the state individual and small-group markets; and
- Maximize the effectiveness of the PPACA's risk-adjustment and risk-pooling requirements.

1. Consistent Rules. The PPACA allows states to continue to regulate their individual and small group insurance markets as long as state laws are not in conflict with federal law. This provides states with the opportunity to require that the rules for the markets inside the exchange be consistent with the rules for markets outside the exchange. The policy goal would be twofold: 1) to reduce variations that might drive insurers away from exchange participation, and 2) restrict the opportunity for insurers who do not participate in an exchange from creating benefit packages and marketing campaigns designed to move healthy persons to outside coverage. As discussed earlier in this paper, states can require plans operating inside an exchange to maintain adequate provider networks, contract with safety net providers, and obtain accreditation on clinical-quality measures.[44] If plans operating outside the exchange do not have to meet these standards, plans within the exchange will be more attractive to persons with greater health risks. This is because, in all likelihood, the exchange plans will feature provider networks with greater availability of medical specialists and sub-specialists than the outside plans. Specifying consistent rules for exchange and non-exchange markets will protect exchange plans.

2. Consistent Pricing. States can also reduce risk by requiring that rules that influence plan premiums are the same inside and outside the exchange. The goal is that individuals and small businesses purchasing on the exchange not be financially penalized when purchasing coverage on the exchange. The concern is that, in 2015, when exchanges must be be financially self-sufficient and not dependent on federal subventions (which expire in 2015), exchanges will begin levying assessments on their carriers, making exchange coverage more expensive. States can eliminate this risk by assessing equivalent fees to carriers in all markets.

Finally, states can gain an additional measure of protection by enforcing insurance regulations in a manner that neither favors nor disfavors exchange plans. Uniform enforcement of consumer protection laws will help protect exchange plans against the risk of adverse selection.

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[43] Lueck, Sarah, "States Should Structure Insurance Exchanges to Minimize Adverse Selection," *Center on Budget and Policy Priorities*, 17 August 2010. http://www.cbpp.org/cms/index.cfm?fa=view&id=3267.

[44] PPACA §1311(c).

3. Offer the Same Coverage Inside and Outside the Exchange. As previously discussed, the PPACA does not mandate insurers to operate inside an exchange, nor does it require insurers offering plans outside the exchange to meet the same regulatory standards as exchange plans. Lueck suggests that:

> Some states, however, may wish to create a selective or competitive process to determine which plans can be offered in an exchange. States may, for example, decide which insurers or products will be available on the basis of price, performance on quality measures, and customer satisfaction, in order to improve the affordability and quality of plans offered through the exchange. Such a model would likely lead to different plan offerings within the exchange compared to the outside markets. However, if a state decides not to use a selective process to pick plans for an exchange, it could help protect against adverse selection by requiring all insurers who wish to offer products in outside markets to also offer coverage in the exchange and to offer the same products (priced the same) both inside and out. **At the very least, states (including those using a selective or competitive process to pick plans for an exchange) can require insurers outside the exchange to offer products in at least the Silver and Gold coverage levels, as they must do inside the exchange.** As noted, the Affordable Care Act establishes the requirement to offer Silver and Gold plans only within the exchange; applying that rule outside the exchange as well would help to ensure more of a basic level of consistency in the products offered inside and outside the exchange and reduce insurers' ability to offer only less comprehensive products — which attract healthier people — outside of the exchange.[45]

Lueck goes on to suggest that states should forbid carriers from restricting their offerings to "[...] *only* Bronze plans or *only* catastrophic plans (as defined by the Affordable Care Act) outside of the exchange."[46] Since these plans offer a lesser level of coverage, and a lower premium, they will be very attractive to healthier individuals and groups, thus increasing the risk that the exchange will suffer an out-migration of healthy people. This appears to be especially true where insurers do not operate on the exchange and are not required to adhere to the "single risk pool" requirement.[47]

4. Merge the Individual and Small-Group Markets. By merging its small-group and individual insurance markets a state will have one exchange and one insurance market serving both individuals and small businesses. This will clearly increase enrollment as there will be one pool and not two separate pools, and as Jost noted, pool size is important in reducing the risk of adverse selection. While larger enrollment alone will not ensure an adequate ratio of healthy persons to sick persons, it is

[45] Lueck, p. 4.

[46] Lueck, p. 4.

[47] Lueck, p. 5.

thought that pool size has the opportunity to enhance that ratio. Higher participation can also drive greater competition amongst insurers in an exchange. Lueck suggests that it is possible that merging the two markets could negatively influence prices for non-grandfathered plans.[48] She notes that when Massachusetts merged its individual market with its larger and more stable small-group market, premium costs decreased modestly for individuals, but caused a small increase in costs for those buying small-group coverage.

Ultimately, the decision to merge markets is a complicated decision and Iowa will want to study its insurance markets carefully prior to taking this step.

5. **Maximize Risk-Adjustment and Risk-Pooling Mechanism Effectiveness.** While the PPACA does contain, as noted above, several important requirements that may protect an exchange against the risk of adverse selection, these mechanism depend on consistent enforcement to be effective.[49] Enforcement will depend on insurers and regulators having access to accurate data on pool participant health status to ensure that risk is being pooled as required by law.

[48] See Lueck, p. 5.

[49] Lueck cites Medicare Advantage as an example demonstrating the need for effective enforcement. "In Medicare Advantage, for example, one significant problem that has impeded effective risk adjustment has been "upcoding," where the information that insurers report about enrollees' health status makes their enrollees appear sicker than they actually are (so that the insurers receive higher payments)." Lueck, p. 5.

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APPENDIX 1

IDPH Planning Grant Application